



TEXAS DEPARTMENT OF INSURANCE

Division of Workers' Compensation - Medical Fee Dispute Resolution (MS-48)

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MEDICAL FEE DISPUTE RESOLUTION FINDINGS AND DECISION

GENERAL INFORMATION

Requestor Name

Universal DME LLC

Respondent Name

Old Republic Insurance Co

MFDR Tracking Number

M4-15-1805-01

Carrier's Austin Representative

Box Number 44

MFDR Date Received

February 18, 2015

REQUESTOR'S POSITION SUMMARY

Requestor's Position Summary: "It has been brought to our attention that HCPCS code E0676 was denied as a duplicate when in fact a quality of two (2) E0676 were delivered."

Amount in Dispute: \$750.00

RESPONDENT'S POSITION SUMMARY

Respondent's Position Summary: Written acknowledgement of medical fee dispute received however no position statement submitted.

SUMMARY OF FINDINGS

Dates of Service	Disputed Services	Amount In Dispute	Amount Due
September 17, 2014	E0676	\$750.00	\$0.00

FINDINGS AND DECISION

This medical fee dispute is decided pursuant to Texas Labor Code §413.031 and applicable rules of the Texas Department of Insurance, Division of Workers' Compensation.

Background

1. 28 Texas Administrative Code §133.307 sets out the procedures for resolving medical fee disputes.
2. 28 Texas Administrative Code §134.203 sets out the reimbursement guidelines for professional medical services.
3. The insurance carrier reduced payment for the disputed services with the following claim bill comments:
 - Per CGS (DME MAC for TX Jurisdiction), the garment/sleeves that are used w/E0676 are included in the payment for E0676 on initial issue and must not be billed separately. The sleeves for EACH limb are included.
 - Only 1 device needed and the sleeves are attached to each limb from the one device.
 - Preauth given for a venoflow compression device (1).

Issues

1. Are the insurance carrier's reasons for denial or reduction of payment supported?
2. Is the requestor entitled to additional reimbursement?

Findings

1. The Division placed a copy of the Medical Fee Dispute Resolution request in the insurance carrier's Austin representative box, which was acknowledged, received on February 26, 2015. Per 28 Texas Administrative Code §133.307(d)(1), "The response will be deemed timely if received by the division via mail service, personal delivery, or facsimile within 14 calendar days after the date the respondent received the copy of the requestor's dispute. If the division does not receive the response information within 14 calendar days of the dispute notification, then the division may base its decision on the available information." The insurance carrier did not submit any response for consideration in this dispute. Accordingly, this decision is based on the information available at the time of review.
2. The requestor states, "...in fact a quantity of two (w) E0676 were delivered." Review of the submitted documentation finds;
 - a. "Delivery Ticket" dated September 16, 2014 shows quantity for E0676 as (1)
 - b. "Approval Determination" from Corvel dated September 15, 2014 states, "Approved VenaPro Compression Device E0676
 - c. Venapro "Quick Start Guide," "Device Summary" ... "The units are supplied clean, non-sterile and packaged in pairs (1 left and 1 right side)

28 Texas Administrative Code §134.203 (b) For coding, billing, reporting, and reimbursement of professional medical services, Texas workers' compensation system participants shall apply the following: (1) Medicare payment policies, including its coding; billing; correct coding initiatives (CCI) edits;" Review of the submitted medical claim finds no evidence the number of units indicated was provided for the date of service. The requestor's position statement is not supported.

3. The documentation requirements of Rule 134.203 were not met. No additional payment can be recommended.

Conclusion

For the reasons stated above, the Division finds that the requestor has not established that additional reimbursement is due. As a result, the amount ordered is \$0.00.

ORDER

Based upon the documentation submitted by the parties and in accordance with the provisions of Texas Labor Code §413.031, the Division has determined that the requestor is entitled to \$0.00 reimbursement for the disputed services.

Authorized Signature

_____ Signature	_____ Medical Fee Dispute Resolution Officer	_____ May 27, 2015 Date
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YOUR RIGHT TO APPEAL

Either party to this medical fee dispute has a right to seek review of this decision in accordance with 28 Texas Administrative Code §133.307, 37 *Texas Register* 3833, applicable to disputes filed on or after June 1, 2012.

A party seeking review must submit a **Request to Schedule a Benefit Review Conference to Appeal a Medical Fee Dispute Decision** (form **DWC045M**) in accordance with the instructions on the form. The request must be received by the Division within **twenty** days of your receipt of this decision. The request may be faxed, mailed or personally delivered to the Division using the contact information listed on the form or to the field office handling the claim.

The party seeking review of the MFDR decision shall deliver a copy of the request to all other parties involved in the dispute at the same time the request is filed with the Division. **Please include a copy of the *Medical Fee Dispute Resolution Findings and Decision*** together with any other required information specified in 28 Texas Administrative Code §141.1(d).

Si prefiere hablar con una persona en español acerca de ésta correspondencia, favor de llamar a 512-804-4812.